Benefit Options
Choice. Value. Health.

STATE OF ARIZONA COBRA ENROLLMENT/CHANGE 2007-2008

□ NEW ENROLLMENT □ QUALIFIED LIFE EVENT □ ADDRESS CHANGE ☐ TERMINATION

AGENCY/PROCESS LEVEL	DATE MEMBER NOTIFIED	DATE REC'D	EFFECTIVE DATE

DURATION OF COBRA COVERAGE

☐ 18 MONTHS ☐ 29 MONTHS (only if disabled at the time of COBRA election) ☐ 36 MONTHS

A. MEMBER IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	SOCIAL SECURITY NUMBER	□ MALE □ FEMALE	□ MARRIED □ SINGLE
STREET ADDRESS		COUNTY	DATE OF BIRTH
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )		HOME PHONE NUMBER ( )
EMPLOYEE LAST NAME, FIRST NAME	EMPLOYEE AGENCY		EMPLOYEE EIN OR SSN

B. MEDICAL PLAN (Employee Monthly Costs Listed)

□ I DECLINE MEDICAL COVERAGE

	CODE	MEMBER	CODE	MEMBER + 1	CODE	FAMILY
CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $471.15	02	☐ $930.74	03	☐ $1259.84
Schaller Anderson Healthcare (SA) EPO	01	☐ $471.15	02	☐ $930.74	03	☐ $1259.84
United Healthcare (UHC) EPO	01	☐ $471.15	02	☐ $930.74	03	☐ $1259.84
Arizona Foundation (AZF) PPO	01	☐ $763.99	02	☐ $1509.25	03	☐ $2042.92
United Healthcare (UHC) PPO	01	☐ $763.99	02	☐ $1509.25	03	☐ $2042.92
SOUTHERN REGION: PIMA AND SANTA CRUZ COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $457.09	02	☐ $902.99	03	☐ $1222.29
Schaller Anderson Healthcare (SA) EPO	01	☐ $457.09	02	☐ $902.99	03	☐ $1222.29
United Healthcare (UHC) EPO	01	☐ $457.09	02	☐ $902.99	03	☐ $1222.29
Arizona Foundation (AZF) PPO	01	☐ $703.47	02	☐ $1389.70	03	☐ $1881.09
United Healthcare (UHC) PPO	01	☐ $703.47	02	☐ $1389.70	03	☐ $1881.09
NORTHERN REGION: YAVAPAI, COCONINO, NAVAJO, AND APACHE COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Schaller Anderson Healthcare (SA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Arizona Foundation (AZF) PPO	01	☐ $798.03	02	☐ $1576.49	03	☐ $2133.94
SOUTHEASTERN REGION: GRAHAM, GREENLEE, AND COCHISE COUNTIES						
RAN/AMN (HMA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Schaller Anderson Healthcare (SA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Arizona Foundation (AZF) PPO	01	☐ $798.03	02	☐ $1576.49	03	☐ $2133.94
WESTERN REGION: MOHAVE, LA PAZ, AND YUMA COUNTIES						
RAN+AMN (HMA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Schaller Anderson Healthcare (SA) EPO	01	☐ $623.51	02	☐ $1231.74	03	☐ $1667.28
Arizona Foundation (AZF) PPO	01	☐ $798.03	02	☐ $1576.49	03	☐ $2133.94
OUT-OF-STATE						
Beech Street PPO	01	☐ $818.02	02	☐ $1616.00	03	☐ $2187.40

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STATE OF ARIZONA ACTIVE
COBRA ENROLLMENT 2007-2008 CONTINUED

C. DENTAL PLAN (Monthly Costs Listed)	SINGLE COVERAGE		FAMILY COVERAGE	
☐ I DECLINE DENTAL COVERAGE	PLAN CODE		PLAN CODE	
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	03	☐ $35.07	04	☐ $112.24
METLIFE DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	07	☐ $34.16	08	☐ $107.24
EMPLOYERS DENTAL SERVICES (EDS) PRE-PAID IN-STATE ONLY	09	☐ $10.40	10	☐ $30.25
ASSURANT BENEFITS PRE-PAID IN-STATE ONLY	01	☐ $11.08	02	☐ $30.11

D. VISION PLAN (Monthly Cost Listed)		
	Plan Code 05	Plan Code 06
☐ I DECLINE VISION COVERAGE	☐ AVESIS SINGLE COVERAGE $6.47	☐ AVESIS FAMILY COVERAGE $17.52

E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER). USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS	DATE OF BIRTH (MM/DD/YY) **REQUIRED**	MEDICARE	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N	ADD OR DELETE A OR D
Employee		**A=Medicare A B=Medicare B C=Medicare A & B D=Medicare unknown E=No Medicare**	**S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild**				
Spouse		☐ A ☐ B ☐ C ☐ D ☐ E	☐ S	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			

F. FLEXIBLE SPENDING	
☐ I DECLINE FLEXIBLE SPENDING	
☐ I AM ELECTING TO MAINTAIN MEDICAL REIMBURSEMENT	MONTHLY AMOUNT $
☐ I AM ELECTING TO MAINTAIN DEPENDENT CARE REIMBURSEMENT	MONTHLY AMOUNT $

G. MEMBER AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is correct and true. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In additon, I have read and understand the declarations.

SIGNATURE:_____ DATE:_____

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 **Revised 09/04/07**